Transgender Health
Volume 5, Number 4, 2020
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DOI: 10.1089/trgh.2020.0005

ORIGINAL ARTICLE

Reduction of Gender Identity Stigma and Improvements in Mental Health Among Transgender Women Initiating HIV Treatment in a Trans-Sensitive Clinic in Argentina

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Abstract

Purpose: Stigma toward transgender women (TGW) increases psychosocial vulnerability, leading to poor mental health and affecting access and retention in HIV care. Trans-sensitive health care (TSHC) has the potential to mitigate this adverse impact. This study aimed to describe baseline characteristics in gender identity stigma (GIS), mental health, and substance use among TGW living with HIV initiating antiretroviral treatment and to analyze changes after 6 months in HIV care in a TSHC clinic in Argentina.

Methods: Sixty-one TGW living with HIV responded to the following questionnaires at baseline and after 6 months in TSHC: sociodemographic, experiences of GIS (in health care, police, etc.), Center for Epidemiologic Studies Depression Scale (CES-D) (depression), State Trait Anxiety Inventory (STAI) (anxiety), Drug Abuse Screening Test (DAST-10) (drug use), Alcohol Use Disorders Identification Test (AUDIT) (alcohol use), 8-item Personal Well-being Index—Adults (PWI-A) (quality of life [QOL]), Personality Inventory for DSM-5—Brief Form (PID-5-BF) (maladaptive personality traits), and Duke Index (social support). Analyses included Pearson correlations to analyze associations between variables; and paired sample *t*-tests, to explore changes between baseline and 6 months.

Results: A significant proportion experienced episodes of GIS the last year in any context. At baseline, 50.8% showed significant depressive symptoms and 65.6% reported any drug use in the last year. At 6 months, participants experienced a significant reduction of GIS, both enacted and internalized, anxiety, drug, and alcohol use, and improvement in QOL. The remaining mental health indicators were not significantly modified.

Conclusion: A TSHC service may have a gender-affirmative impact on TGW initiating HIV care that contributes to reduce GIS and substance use and improve mental health. This highlights the importance that HIV care programs for TGW comply with trans-sensitive essential components to enhance retention.

Keywords: transgender women; HIV; gender identity stigma; mental health; trans-sensitive health care

Introduction

As in many other contexts, Argentinian transgender women (TGW) experience marginalization and social exclusion, placing them in high levels of vulnerability.[1,2] This is mainly a consequence of gender identity stigma (GIS),[3] both enacted and internalized. Whereas *enacted GIS* comprises concrete experiences of discrimination and mistreatment from others,[4] *internalized GIS* includes negative emotions (e.g., shame), anticipation of rejection, and self-exclusion from social activities to avoid discrimination.[5]

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Owing to enacted GIS, and like in most countries, many TGW in Argentina are expelled from their homes and formal education at early age, which further limits access to formal employment and housing.[2,6,7] Consequently, a significant proportion of TGW engage in survival sex work,[8] which increases exposure to violence. TGW can internalize this social prejudice in their self-concept, leading to self-devaluation and anticipation of stigma. Owing to internalized GIS, TGW are at increased risk of developing emotional disorders, such as depression, anxiety,[9] suicide behavior,[10] and substance use as a coping strategy.[4,11–14] These conditions have been found to augment the risk of negative health outcomes, such as increased sexual risk behavior[15–17] and HIV prevalence.[15,18,19] Current HIV prevalence among Argentinian TGW rises to 34%.[20]

GIS in health care services may undermine the confidence of TGW in the system, discouraging them from seeking assistance.[21,22] In Argentina, it is associated with TGW's reluctance to attend health care services.[23] This impacts HIV care: TGW showed lower adherence to antiretroviral treatment (ART) and increased odds of not achieving durable viral suppression, compared with cisgender men.[24,25] GIS, and negative mental health outcomes and substance use, were associated with lower engagement in HIV care in TGW.[26–28]

Trans-sensitive health care (TSHC) can positively contribute to the HIV care continuum. TSHC is responsive, respectful, and affirming to transgender patients' identities and/or expressions while holistically attending to their health needs.[29] Several studies, including a local one, have identified essential components of TSHC: (1) use of patient's preferred name and pronoun in interactions and clinical records (which should include sex assigned at birth and gender identity); (2) trans-competent trained providers, aware of transgender people's needs and accepting of their identities; (3) integration of multiple services (e.g., HIV, gender-affirming procedures) to simplify service delivery; (4) adjustment to transgender populations' social contexts (e.g., flexible scheduling and hours); and (5) inclusion of peer navigators that link patients with services and assist them along the care continuum.[29–31]

TSHC services can promote individuals' gender affirmation (GA),[32] which is the interpersonal process through which a person's gender identity and expression is socially recognized and supported.[33] GA produces a reduction of internalized GIS[33,34] and is associated with higher psychological wellbeing and less symptoms of depression, anxiety, and post-traumatic stress.[34–36] A TSHC service provides GA both by positively accepting and recognizing transgender identities and by facilitating access to affirming medical and psychological procedures. By contributing to GIS reduction and improvements in mental health, TSHC can facilitate access to testing and treatment, avoiding late diagnosis and delays in ART initiation, and increasing the odds of retention in HIV care.[26,37]

However, local information describing TGW receiving HIV care in a trans-sensitive clinic is scarce. Therefore, this study aimed to describe baseline characteristics in GIS, mental health indicators, and substance use among TGW living with HIV initiating ART and to analyze changes after 6 months in HIV care at a TSHC service.

Methods

Participants

The sample consisted of 61 TGW who met the following inclusion criteria: self-identified as TGW, older than 18 years, recently diagnosed with HIV, and naive of ART. Participants initiated ART with dolutegravir–tenofovir–emtricitabine at the clinic, as part of a larger clinical trial that tested the efficacy of this treatment in naive TGW, as its characteristics were expected to facilitate retention in this population. Participants were recruited by outreach efforts from peer navigators and/or were invited to participate after testing positive for HIV in domiciliary or community-based testing activities. Seventy-five TGW were screened, and 61 were finally enrolled.

Materials and measures

Gender identity stigma. This *ad hoc* designed scale combined items from the HIV Stigma Index[38,39] and the Everyday Discrimination Scale (EDS), and was used in previous studies with TGW in Argentina.[40] Items were adapted by modifying the wording from "due to your HIV status" to "due to your gender identity." The questionnaire consisted of 34 items, using a 5-point Likert scale (1 = *never* to 5 = *always*) that assessed both internalized (14 items, e.g., "I felt ashamed") and perceived enacted GIS (20 items, e.g., "I was excluded from family activities") in the last year. Higher scores indicate higher levels of GIS. Omega values for this sample were 0.96 (Total GIS), 0.94 (Enacted), and 0.95 (Internalized).[41]

In addition, to asses GIS experiences in the last year, participants were given a list of items/situations of discrimination that frequently occur to TGW in different settings, validated in a previous study,[6] and were asked

if they had experienced any of them the past year. Affirmative responses to at least one item/situation from the previous scales that described *physical or sexual violence from partner, client, and/or police* were combined to measure these variables.

Depressive symptoms. The Center for Epidemiologic Studies Depression Scale (CES-D) was used to evaluate depressive symptoms in the last 7 days.[42] Responses to the 20 items range from 0 = *rarely* to 3 = *most or all of the time*. A score of ≥16 was defined as significant presence of depressive symptoms. The omega value in this sample was 0.94.

Four items were used to screen for *suicidal ideation* in the past week: "I have had thoughts related to death," "I have felt that my family and friends would be better off if I died," "I have had thoughts about killing myself," and "I think I could kill myself if I knew how to," using the CES-D's response scale. Omega value for these items was 0.95.

Anxiety. Anxiety was assessed with the 20 State Anxiety Items of the State Trait Anxiety Inventory (STAI).[43] Participants rated each item using a 4-point Likert scale (from *Nothing* to *A lot).* Higher scores indicate greater levels of anxiety. The omega value for this scale was 0.91.

Maladaptive personality traits. The Personality Inventory for DSM-5—Brief Form (PID-5-BF) comprises 25 items rated on a 4-point scale (0 = *very false or often false* to 3 = *very true or often true*).[44,45] It assesses five maladaptive personality traits: negative affect, detachment, antagonism, disinhibition, and psychoticism. The omega value of the total scale was 0.91.

Alcohol use. Participants responded to the Alcohol Use Disorders Identification Test (AUDIT), a 10-item screening tool to assess behaviors or events related to alcohol consumption.[46] Scores of ≥8 indicate *hazardous alcohol use*. The omega value for this sample was 0.83.

Drug use. The Drug Abuse Screening Test (DAST-10) consists of 10 items that ask about behaviors, feelings, or events related to drug use in the past 12 months, using dichotomic responses (yes/no).[47,48] Scores ≥6 indicate possible *drug abuse or dependence problems*. Additional questions gathered information about frequency and type of drug use.

Quality of life. The 8-item Personal Wellbeing Index—Adults (PWI-A) explores satisfaction with different life domains, using a scale from 0 = *No satisfaction at all* to 10 = *Completely satisfied*.[49] As this response scale has more than 7 points, Cronbach's alpha was a more adequate indicator of internal consistency: for this sample, it was 0.77.

Social support. Social support was assessed with the Abbreviated Duke Social Support Index,[50] with 11 items responded on a 5-point scale. Higher scores revealed greater availability and satisfaction with social support. The omega value for this sample was 0.92. *Support from family* was assessed through one question ("How supportive do you feel your family of origin (parents and/or siblings) is regarding your transgender identity?"), with responses ranging from 1 = *Not at all supportive* to 7 = *Extremely supportive*, whereas *Support from peers* was evaluated combining two questions: "What portion of your social time is spent with transgender people?" (1 = *None of the time* to 7 = *All of the time*) and "How often have you felt like you were the only transgender person in the area where you live?" (1 = *Never* to 7 = *Always*).[51]

HIV care outcomes. A participant was categorized as "not retained in HIV care" after 3 months of missed medical visits and missed pharmacy fills, and 'virally suppressed' when having <40 viral load.

Sociodemographic characteristics. Questions assessed age, place of birth, type of housing, educational level, sexual behavior, and engagement in sex work.

Procedures

The study was approved by the Ethical Committee of the institution. Participants received information about the aims and procedures of the study and signed informed consent.

Participants received health care by an interdisciplinary team conformed by infectious diseases specialists, psychologists, and peer navigators. Although no specific program targeting mental health issues was provided, initial 2 or 3 counseling sessions and facilitated referral to mental health services were granted to those who required it. The clinic was defined as a *trans-sensitive service* as it complies with the guidelines of World Professional Association for Transgender Health (WPATH),[52] and includes the essential components of TSHC previously outlined. The questionnaires

were administered by a psychologist or a peer navigator, at the clinical research site, by computer at baseline and after 6 months in HIV care. Peer navigators were trained in interviewing skills and good clinical practice.

Statistical analyses

Statistical analyses were assisted by the Statistical Package for the Social Sciences v24.[53] Frequencies, percentages, means, and standard deviations (SDs) were used to describe participants' characteristics. Pearson correlations were conducted to analyze associations between variables. Differences between baseline and 6 months were explored through paired sample *t*-tests. Internal consistency of the measures was evaluated using the coefficient omega, as recommended,[54] and calculated with the *psych* package in R version 3.5.3.

Results

Descriptive statistics

Mean age was 29.87 (SD = 6.51) years. A considerable number (19.7%) met the criteria for late diagnosis (CD4 < 200), showing late arrival to testing and entry into treatment. At baseline, most participants were in a context of high psychosocial vulnerability, with a significant proportion living in unstable housing and engaging in sex work, and 88.5% had experienced any GIS in the past year (Table 1). Almost all participants had engaged in sexual relationships with cisgender men in the last month (96.7%). Enacted GIS was mainly reported in health care services by nearly half of the participants (45.9%), followed by sex work venues (44.3%), especially from clients. Almost half of the TGW (47.5%) experienced violence from partners, clients, or police in the last year, both physical (44.3%) and sexual (32.8%).

Mental health indicators showed significant psychological distress and emotional problems (Table 1). Half the participants (50.8%) presented depressive symptoms and 23%, significant negative affect. Regarding substance use, 65.6% had used at least one type of drug in the last year, marijuana (54.1%) and cocaine (52.5%) being the most frequent. From these participants, 13.1% met the criteria for severe drug abuse and dependence, whereas 52.5% of the total sample met the criteria for hazardous alcohol drinking.

Table 1. Sample Characteristics at Baseline

Sociodemographic and health characteristics	*n* (%) (total = 61)
Foreign born	
Yes	18 (29.5)
No	43 (70.5)
Highest educational attainment	
High school or greater	24 (39.3)
Less than high school	37 (60.7)
Unstable housing	
Yes	32 (52.5)
No	28 (45.9)
Survival sex work (current)	
Yes	47 (77.0)
No	14 (23.0)
Survival sex work (lifetime)	
Yes	57 (93.4)
No	4 (6.6)
Late entry (< 200 CD4)	
Yes	12 (19.7)
No	49 (80.3)
Mental health and substance use	
Depressive symptoms (CES-D > 16)	
Yes	31 (50.8)
No	30 (49.2)
Hazardous drinking (AUDIT > 8)	
Yes	32 (52.5)
No	29 (47.5)
Drug abuse (DAST > 6)	
Yes	8 (13.1)
No	53 (86.9)
Use of cocaine (last year)	
Yes	32 (52.5)
No	29 (47.5)
Use of marijuana (last year)	
Yes	33 (54.1)
No	28 (45.9)
GIS, discrimination and violence	
GIS in any context (last year)	
Yes	54 (88.5)
No	7 (11.5)
GIS in different contexts (yes/last year)	
Workplace	35 (57.4)
Health care	28 (45.9)
Sex work venues	27 (44.3)
Government offices	20 (32.8)
Housing	18 (29.5)
Security forces/police	11 (18.0)
Educational institutions	6 (9.8)
Violence from partner, clients or police (last year)	
Physical	27 (44.3)
Sexual	20 (32.8)

AUDIT, Alcohol Use Disorders Identification Test; CES-D, Center for Epidemiologic Studies Depression Scale; DAST, Drug Abuse Screening Test; GIS, gender identity stigma.

Correlations between GIS, mental health indicators and substance use

Total GIS positively correlated with all indicators of psychological distress: anxiety, depression, suicidal ideation, and overall maladaptive personality traits (Table 2). Regarding substance use, total GIS positively correlated with drug use, but not with alcohol use. Furthermore, GIS negatively correlated with quality of life (QOL) and support from family, and positively correlated with peer support.

Table 2. Pearson Correlations Between GIS, Mental Health Indicators, and Substance Use

	Depressive symptoms	Suicidal ideation	Anxiety	Drug use	Alcohol use	Total	Negative Affect	Maladaptive personality traits				QOL	Social Support	Support from family	Support from peers
								Disinhibition	Psychoticism	Detachment	Antagonism				
Total GIS	0.50**	0.49**	0.48**	0.35**	0.17	0.37**	0.36**	0.27*	0.34**	0.24	0.16	−0.35**	−0.23	−0.50**	0.32*
Enacted GIS	0.42**	0.34**	0.37**	0.28*	0.07	0.21*	0.28*	0.25*	0.32**	0.15	0.12	−0.22	−0.16	−0.56**	0.38**
Internalized GIS	0.48**	0.54**	0.49**	0.36**	0.23	0.35**	0.37**	0.24	0.29*	0.27*	0.16	−0.40**	−0.26*	−0.35**	0.21

**$p < 0.01$, *$p < 0.05$
QOL, quality of life.

Similar correlations were found for GIS dimensions. Both enacted and internalized GIS positively correlated with all the mental health indicators and drug use and negatively correlated with familial support. In addition, internalized GIS negatively correlated with QOL and general social support. A moderate positive association was found between enacted GIS and peer support. Nevertheless, no significant correlation was found between enacted GIS, QOL, and general social support.

Comparisons between baseline and 6 months

At 6 months, 82% ($n = 50$) were retained in HIV care and 77.6% had achieved viral suppression. Presence of depressive symptoms was reduced to 42%, although this decrease was not statistically significant.

After 6 months, a significant reduction was observed in total GIS ($t(49) = 5.38$, $p \leq 0.000$); and its dimensions—enacted ($t(49) = 5.13$, $p \leq 0.000$) and internalized ($t(49) = 4.33$, $p \leq 0.000$)—with medium effect sizes.[55] Drug ($t(49) = 2.75$, $p < 0.01$) and alcohol use ($t(49) = 2.14$, $p < 0.05$) significantly decreased. A significant reduction of anxiety ($t(49) = 1.93$, $p < 0.05$) and improvement of QOL ($t(49) = -2.85$, $p < 0.01$) were found. Effect sizes of these differences were small.[55] The remaining mental health indicators were not significantly modified (Table 3).

Discussion

This study sought to describe baseline characteristics in GIS, mental health, and substance use in TGW initiating ART and to analyze changes after 6 months in HIV care at a TSHC service.

After 6 months in care, reduction of GIS (both internalized and enacted) and substance use and improvement in certain mental health indicators were observed, despite no specific psychosocial intervention was conducted with that purpose. It might be inferred that attending a TSHC service may be playing a role in these results. As posited, a TSHC service can have a social and psychological gender-affirming effect that positively impacts mental health and psychological wellbeing, through a reduction of internalized GIS.[33,34,56] A gender-affirming social environment may contribute to reduce shame and self-devaluation (internalized GIS) and increase wellbeing by recognizing and legitimizing trans identities. This reduction of internalized GIS may also have contributed to the observed decrement in perceived enacted GIS. Possibly, TGW with lower internalized GIS are less

Table 3. Means and Standard Deviations at Baseline and 6 Months and Paired Sample *t*-Tests

	Mean (SD)				
	Baseline	6 Months	*t*	*p*	Cohen's *d*
Anxiety	43.34 (10.05)	40.70 (12.13)	1.94	0.058	0.27
Depressive symptoms	18.84 (11.35)	15.96 (13.19)	1.65	0.106	
Suicidal ideation	0.88 (2.18)	0.94 (2.41)	−0.18	0.860	
Maladaptive personality traits	33.72 (13.55)	31.94 (16.75)	0.96	0.341	
GIS (total)	59.26 (18.85)	48.30 (12.89)	4.34	0.000	0.76
GIS (enacted)	34.02 (9.50)	28.66 (6.90)	5.14	0.000	0.72
GIS (internalized)	25.24 (11.16)	19.64 (7.17)	4.34	0.000	0.61
Alcohol use	12.88 (19.73)	7.20 (6.37)	2.14	0.037	0.35
Drug use	1.84 (2.02)	1.14 (1.38)	2.75	0.008	0.39
QOL	63.06 (9.81)	66.48 (9.64)	−2.86	0.006	0.40
Social support	41.92 (8.97)	42.80 (10.80)	−0.50	0.621	
Support from peers	8.48 (2.69)	9.14 (2.49)	−1.88	0.066	
Support from family	6.08 (1.83)	6.18 (1.62)	−0.430	0.669	

SD, standard deviation.

hypervigilant, reducing awareness or perception of stigmatizing situations, thus reporting less enacted GIS. Moreover, a TSHC service may contribute to rebuild trust in health care providers, as the rejection that TGW anticipated from them was not confirmed by facts. This confidence may be generalized to other contexts diminishing the overall perception of stigma. Furthermore, as past experiences of stigma in health care services are one of the main predictors of avoidance of seeking health care, it is likely that a free of stigma TSHC service facilitated access and retention in HIV care.[22,23] The elevated rate of retention (82%) in this study was considerably higher than the rate obtained by the same team in a regular infectious diseases service from a public hospital in Buenos Aires (46.4%).[37]

GIS reduction was accompanied by improvement in certain mental health indicators at 6 months. Excess of chronic social stress, because of the experience or constant expectation of stigma, known as minority stress, underlies the high levels of negative mental health outcomes in TGW.[9,57] In this study, poor mental health indicators and drug use were positively associated with GIS at baseline. Reduction of anxiety at 6 months may reflect a decrement in minority stress, as expectations and fear of discrimination, consequence of experiences with health care providers, were not confirmed or replicated in this TSHC clinic. This reduction may be also explained by the fact that most participants were recently diagnosed. An HIV diagnosis can be a traumatic or significantly stressful event, which may trigger high levels of anxiety. This is mostly because of concerns related to the efficacy of the ART or its effects that still persist among TGW.[58–60] After 6 months, 77.6% of the TGW retained in HIV care reached undetectable viral load. This may have contributed to diminish worries or myths about HIV, consequently decreasing anxiety.

On the contrary, depressive symptoms, which at baseline were as high as the prevalence rates found worldwide among TGW,[12,61–64] were not modified after 6 months. Although anxiety is more prone to fluctuate according to circumstances, depression seems to be more stable and harder to reduce. It is highly possible that, given the high levels of depression found in this sample, a TSHC service may not be enough. Despite the existence of a Gender Identity Law that recognizes the right to a self-defined gender identity,[65] TGW in Argentina continue to endure GIS, in a context of high psychosocial vulnerability, as descriptive results showed. This situation may be fueling the elevated prevalence of depression among TGW,[61] and clinics that assist this population should consider providing specific treatment.

Reductions in substance use were also observed. An increased concern in one's own health and positive changes in health-related behaviors have been reported in different populations, such as cisgender women and men who have sex with men, motivated by an HIV diagnosis.[66,67] This includes reducing or even giving up drug and alcohol use, among other behaviors. Researchers have explained this change as a consequence of an increased appreciation of one's life and as a coping response that seeks to recover a sense of control over one's body and health.[66,68]

Improvements in QOL are an expected outcome of receiving appropriate HIV care. As mentioned, almost 20% of the participants were lately diagnosed and had

detectable viral load, possibly enduring the physical symptoms of HIV progression that might have reduced their functionality and wellbeing. After 6 months, most of the TGW retained in HIV care were virally suppressed. Increments in the perceived QOL may reflect the recovery of functionality and general wellbeing that follows improvements in HIV indicators. Moreover, the gender-affirming effect of the TSHC service might have boosted psychological wellbeing, which is the subjective component of QOL.[34] Gender-affirming environments, respectful and welcoming with transgender people, can increment and promote several dimensions of psychological wellbeing, such as a sense of belonging, acceptance from others, and self-acceptance.[69] These dimensions are associated with positive mental health outcomes and function as resources to adaptively cope with gender identity and HIV-related stigmas in TGW.[70,71] In sum, a TSHC service might have a positive impact on transgender people's psychological wellbeing and mental health, independent of additional specific psychological interventions that could be conducted.

Nonetheless, this study presents limitations that must be acknowledged. First, a small nonprobabilistic sample was recruited, which may limit the generalizability of results. Participants were newly HIV diagnosed TGW naive of ART that may not be representative of the whole population. Second, although an association between a TSHC service and changes in mental health indicators was inferred, more rigorous designs (e.g., randomized studies) and statistical analysis (e.g., moderation/mediation) are needed to test for causality and to elucidate the specific influence of TSHC services on TGW's positive health outcomes. This will also implicate to standardize the requirements for a clinic to be acknowledged or certified as trans-sensitive to enable comparability among services. Third, although our measure for GIS allows comparisons with previous local studies, future research would benefit by incorporating more valid and reliable international instruments or by conducting a local validation of this measure.

Despite the study's limitations, these results can be considered initial evidence that TSHC services may have a positive role in TGW's mental health and wellbeing, favoring retention in the HIV continuum of care. Future studies might explore the generalization of trans-sensitive guidelines to other settings, such as educational institutions, and its effect on transgender people's wellbeing in other domains of life.

Conclusion

Assessment after 6 months of HIV care shows improvements in mental health indicators and reduction of GIS and substance use in TGW initiating HIV treatment. This preliminary evidence suggests that these changes may be partially related to the service being trans-sensitive. This is an initial contribution to a topic that has been understudied in the Latin American region. These findings also highlight the relevance of creating welcoming and accepting environments for transgender people that facilitate and guarantee their access to basic services and human rights and the improvement of their QOL.

Acknowledgments

The authors thank all the participants and collaborators: Asociación de Travestis, Transexuales y Transgéneros de Argentina (A.T.T.T.A) and Asociación Civil Hotel Gondolin.

Author Disclosure Statement

No competing financial interests exist.

Funding Information

Funding was provided by ViiV Health care, GSK 202037.

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Cite this article as: Radusky PD, Zalazar V, Cardozo N, Fabian S, Duarte M, Frola C, Cahn P, Sued O, Aristegui I (2020) Reduction of gender identity stigma and improvements in mental health among transgender women initiating HIV treatment in a trans-sensitive clinic in Argentina, *Transgender Health* 5:4, 216–224, DOI: 10.1089/trgh.2020.0005.

Abbreviations Used

ART = antiretroviral treatment
AUDIT = Alcohol Use Disorders Identification Test
CES-D = Center for Epidemiologic Studies Depression Scale
DAST-10 = Drug Abuse Screening Test
EDS = Everyday Discrimination Scale
GIS = gender identity stigma
PID-5-BF = Personality Inventory for DSM-5—Brief Form
PWI-A = 8-item Personal Wellbeing Index—Adults
QOL = quality of life
SD = standard deviation
STAI = State Trait Anxiety Inventory
TGW = transgender women
TSHC = Trans-sensitive health care
WPATH = World Professional Association for Transgender Health